SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*43800*
Company Tracking Number:	*AR A30 RECOVERY CARE*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*AR A30 Recovery Care*		
Project Name/Number:	*AR A30 Recovery Care/LM AR A30 Recovery Care*		

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR A30 Recovery Care	SERFF Tr Num: MDIC-126340784	State: Arkansas
TOI: H13I Individual Health - Short Term Care	SERFF Status: Closed-Approved-Closed	State Tr Num: 43800
Sub-TOI: H13I.002 Nursing Home	Co Tr Num: AR A30 RECOVERY CARE	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Luanne Melies	Disposition Date: 10/27/2009
	Date Submitted: 10/15/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: AR A30 Recovery Care	Status of Filing in Domicile: Pending
Project Number: LM AR A30 Recovery Care	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: We have filed the A30 Recovery Care Policy in our domicile state of Nebraska and are awaiting approval.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/27/2009	Explanation for Other Group Market Type:
	State Status Changed: 10/27/2009
Deemer Date:	Created By: Luanne Melies
Submitted By: Luanne Melies	Corresponding Filing Tracking Number:

Filing Description:

Filing of our new MI-NHA30 Recovery Care Policy with associated forms.

Company and Contact

Filing Contact Information

Luanne Melies, Compliance Analyst	lmelies@gomedico.com

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*43800*
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1515 S. 75th Street
Omaha, NE 68124

800-695-5976 [Phone] 249 [Ext]
402-391-4858 [FAX]

Filing Company Information

Medico Insurance Company	CoCode: 31119	State of Domicile: Nebraska
1515 S. 75th Street	Group Code:	Company Type: Life and Health
Omaha, NE 68124	Group Name: Medico	State ID Number:
(800) 695-5976 ext. [Phone]	FEIN Number: 47-0122200	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Normal fees are $50.00 for each policy including all forms associated with the policy and filed with the policy.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	$50.00	10/15/2009	31318405

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/27/2009	10/27/2009

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
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Disposition

Disposition Date: 10/27/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	MI9F-2701(AR)	Approved-Closed	Yes
Supporting Document	MI9F-1060	Approved-Closed	Yes
Supporting Document	MI9F-4218	Approved-Closed	Yes
Supporting Document	AR Cover Letter	Approved-Closed	Yes
Supporting Document	AR Filing Fee Certification	Approved-Closed	Yes
Form	A30 Policy	Approved-Closed	Yes
Form	A30 Policy Schedule	Approved-Closed	Yes
Form	Toll-Free Customer Service Notice	Approved-Closed	Yes
Form	Medicare Duplication Notice	Approved-Closed	Yes
Form	Survivorship Benefit Rider	Approved-Closed	Yes
Form	Inflation Protection Rider (simple)	Approved-Closed	Yes
Rate	A30 Rates Individual	Approved-Closed	Yes
Rate	A30 Rates Association	Approved-Closed	Yes

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: MI-NHA30(AR)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/27/2009	MI-NHA30(AR)	Policy/Contract/Fraternal Certificate	A30 Policy	Initial			MI-NHA30(AR)-10122009.pdf
Approved-Closed 10/27/2009	A30 Policy Schedule	Schedule Pages	A30 Policy Schedule	Initial			A30 Policy Schedule.pdf
Approved-Closed 10/27/2009	MIR-AR-763	Other	Toll-Free Customer Service Notice	Revised	Replaced Form #: UR-AR-763 Previous Filing #: MDIC-125606274		MIR-AR-763-10122009.pdf
Approved-Closed 10/27/2009	MI9F-4185RC	Other	Medicare Duplication Notice	Initial			MI9F-4185RC-06162009.pdf
Approved-Closed 10/27/2009	MIRA34	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Survivorship Benefit Rider	Initial			MIRA34-09112009.pdf
Approved-Closed 10/27/2009	MIRA38	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Inflation Protection Rider (simple)	Initial			MIRA38-06292009.pdf

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
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nt or Rider

MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124 • 1-800-228-6080

RECOVERY CARE POLICY

CAUTION: **The issuance of this policy is based upon your responses to the questions on your application. A copy of your application is attached to the policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.**

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefit Period Provision, as long as the premium is paid within the allowable time. We do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form, or optional riders attached to this form, issued to persons of your class in your state. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy or any rider, we will send you notice at least 30 days (31 days in South Carolina and 60 days in Mississippi) before your premium is due.

PART C PRE-EXISTING CONDITIONS LIMITATION

We will not cover any loss or confinement due to a pre-existing condition if the loss occurs or the confinement begins within the first six months (180 days) after your Policy Date. A pre-existing condition means a condition for which a prudent person would seek medical advice or treatment, or for which medical advice was given or treatment was received from a Licensed Health Care Practitioner within six months before your Policy Date.

NOTICE TO BUYER: **This policy may not cover all of the costs incurred by the buyer during the period of coverage. The buyer is advised to carefully review all policy limitations.**

LIMITED BENEFIT POLICY
FOR NURSING FACILITY CARE, ASSISTED LIVING FACILITY CARE, HOME HEALTH CARE, ADULT DAY CARE AND HOSPICE CARE
THIS IS NOT A LONG-TERM CARE POLICY

Insuring Clause: **We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.**

ALPHABETICAL GUIDE TO YOUR POLICY

PART D EXCEPTIONS

We will NOT pay benefits for:

1. loss that occurs while this policy is not in force;
2. intentional, self-inflicted injury or attempted suicide (in Colorado or Missouri, while sane);
3. Mental or Nervous Disorders without demonstrable organic disease **(subject to the other policy provisions, we will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the policy);**
4. alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. injuries received or caused in consequence of your being intoxicated or under the influence of any controlled substance, unless administered on the advice of a Physician;
6. loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation;
7. care or services provided by a member of your Immediate Family;
8. services for which you are not liable or for which no charge normally is made in the absence of insurance;
9. loss that occurs outside the territorial limits of the United States; and
10. drugs or supplies.

PART E LIFETIME MAXIMUM BENEFIT PERIOD

All benefit payments are limited to the Lifetime Maximum Benefit Period, which is shown in the Schedule. Coverage under this policy automatically ends after we have paid benefits up to the Lifetime Maximum Benefit Period, unless the policy is kept in force by the continued payment of premiums that become due, as stipulated in Part K, Restoration of Lifetime Maximum Benefit Period. Only days for which services are rendered will count toward the Lifetime Maximum Benefit Period.

PART F DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

Activities of Daily Living: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence; and (f) bathing. You are considered to need assistance for each of these activities when:

Eating: You cannot, without Substantial Assistance from another person, feed yourself by getting food into your body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Dressing: You cannot, without Substantial Assistance from another person, put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: You cannot, without Substantial Assistance from another person, get to and from the toilet, get on and off the toilet and perform associated personal hygiene.

Transferring: You cannot, without Substantial Assistance from another person, move into or out of a bed, chair or wheelchair.

Continence: You cannot, without Substantial Assistance from another person, maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, perform associated personal hygiene (including caring for catheter or colostomy bag).

Bathing: You cannot, without Substantial Assistance from another person, wash yourself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Adult Day Care: A program for six or more individuals, of social- and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired, elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center: (a) a facility licensed or certified by the state in which it is located to provide Adult Day Care; (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a Hospital or any type of Nursing Facility by the state in which it is located; or (c) a facility that is approved for Medicaid.

Anniversary Date: The same day and month as the Policy Date in each subsequent year.

Assisted Living Facility: A facility where shelter, food and care are provided for remuneration for a period of more than twenty-four consecutive hours to four or more persons residing at such facility who require or request such services due to age, illness or physical disability.

Assisted Living Facility does not include a home, apartment or facility where (a) casual care is provided at irregular intervals or (b) a competent person residing in such home, apartment or facility provides for or contracts for his or her own personal or professional services if no more than twenty-five percent of persons residing in such home, apartment or facility receive such services.

Assisted Living Facility Care: Assistance services to support resident needs and promote resident self-direction and independence provided in an Assisted Living Facility.

Benefit Period: (a) days of confinement in a Nursing Facility, Assisted Living Facility or Hospice Care Facility; (b) days of Home Health Care Services or Adult Day Care Services; or (c) any sequence of (a) and (b). It includes days of Covered Care due to the same or related conditions that are not separated by at least 180 days, during which you are free of such Covered Care.

Cognitive Impairment: Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder. You must require continual supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

1. Your short- or long-term memory;
2. Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);
3. Your deductive or abstract reasoning; and
4. Your judgment as it relates to safety awareness.

Such loss in intellectual capacity can result from Alzheimer's disease or related degenerative and dementing illnesses.

Covered Care: Care or services due to Injury or Sickness for which benefits are payable under this policy, or would have been payable except for any Elimination Period. This includes Nursing Facility Care, Assisted Living Facility Care, Home Health Care, Adult Day Care and Hospice Care.

Elimination Period: The number of days for which no benefits are payable. The Elimination Period starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only days in which services are actually rendered will satisfy your Elimination Period. You will only be required to satisfy one Elimination Period per Benefit Period.

Home: Any place where you reside other than an institutional setting. Examples of institutional settings include, but are not limited to, a Nursing Facility, Assisted Living Facility, Hospital or any other type of residential care facility.

Home Health Agency: An entity that provides Home Health Care and is: (a) certified for participation in the Medicare program; (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

Home Health Care: One or more of the following medically appropriate services for your care and treatment that are provided by a Home Health Agency in your Home according to a written diagnosis and Plan of Care:

1. nursing and related personal care services under the direction of a registered Nurse, including home health aide services;
2. physical therapy;
3. speech therapy;
4. respiratory therapy;
5. occupational therapy;
6. nutritional services provided by a licensed dietician;
7. home health aide services (which include assistance in your Home with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications and other related services provided by a Home Health Agency; and
8. other similar medical services and health-related support services.

Hospice Care: Services (not drugs or other supplies) provided by an agency or a facility which is licensed by your state of residence to provide Hospice Care in your Home or in a Hospice Care Facility. This type of care is designed to provide you with supportive care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Physician as having no more than six months to live.

Hospice Care Facility: A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

Hospital: An institution licensed or certified as a Hospital by the state in which it is located that:

1. charges for its services;
2. is devoted primarily to the diagnosis, care and treatment of Injury or Sickness requiring resident inpatient stays of 24 hours or more;
3. has licensed professional Nurses on duty 24 hours a day who are under the direction of a Physician; and
4. provides medical, radiological, dietary, surgical and pharmaceutical services to two or more unrelated individuals suffering from Injury or Sickness.

No benefits are payable for confinement to a Hospital.

Immediate Family: Your spouse, parent, child, brother or sister or any person living with you.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Licensed Health Care Practitioner: Any Physician, registered professional Nurse, licensed social worker or other individual who meets requirements prescribed by the United States Secretary of the Treasury, other than a member of your Immediate Family.

Mental or Nervous Disorder: A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

Nurse: A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.).

Nursing Facility: A health care facility that is licensed as a Nursing Facility by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must:

1. provide this care on a continuing inpatient basis as prescribed by a Plan of Care;
2. supervise the care through a nursing staff;
3. maintain clinical records for all patients;
4. maintain control and records of medications given; and
5. have arrangements for the services of a Physician to furnish medical care in case of an emergency.

The specific section or unit of the facility where you receive Nursing Facility Care must meet the above-described licensing requirements. It must also provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (3) and (4) do not apply when you receive only Custodial Care.)

The requirements above typically are met by licensed skilled nursing facilities, comprehensive nursing care facilities and intermediate nursing care facilities, as well as some specialized wards, wings and units of Hospitals. The requirements generally are NOT met by: rest homes; homes for the aged; retirement homes; community living centers; Adult Day Care or educational care facilities; residential sections or wings of Nursing Facilities; or places used primarily for the care and treatment of alcoholism, drug addiction, or mental diseases or disorders.

Nursing Facility Care: Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Facility.

1. **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.
2. **Custodial Care** means care that is given to residents of a Nursing Facility who, not needing daily nursing care, cannot properly care for themselves due to age, Sickness, disease, or physical or mental impairment. This care must be prescribed in your Plan of Care.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license and legally entitled to practice in the state or jurisdiction in which services are performed, other than a member of your Immediate Family. Practitioners of homeopathic, naturopathic and related medicines are not Physicians.

Plan of Care: A written document prescribing individualized treatment or services that your condition requires. The plan must be prepared by a Licensed Health Care Practitioner and approved by your Physician. The Plan of Care must be updated or recertified at least once every 90 days, and your Physician must approve the updated or recertified plan.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

Substantial Assistance: You need hands-on or stand-by assistance to perform an Activity of Daily Living. Hands-on assistance means the physical assistance of another person without which you would be unable to perform an Activity of Daily Living. Stand-by assistance means the presence of another person within arm's reach of you that is necessary to prevent, by physical intervention, Injury to you while you are performing an Activity of Daily Living.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART G GENERAL BENEFIT INFORMATION

The Schedule Shows:

1. The Daily Benefit Amount, which is the basis for our payment of the services we cover. This amount may be greater than that shown in the Schedule if the optional Inflation Protection Rider is in force.
2. The Elimination Period, which is applied once per Benefit Period.
3. The Lifetime Maximum Benefit Period, which is the maximum period for which we will pay benefits during the lifetime of the policy, as described in Part E, unless the policy's Lifetime Maximum Benefit Period has been restored as stipulated in Part K, Restoration of Lifetime Maximum Benefit Period.

PART H ELIGIBILITY FOR PAYMENT OF BENEFITS

To be eligible for any type of benefit under this policy, your Physician or Licensed Health Care Practitioner must show that you meet one of the following benefit qualifiers:

1. Loss of Functional Capacity: You need Substantial Assistance to perform at least two of the six defined Activities of Daily Living.
2. Cognitive Impairment: You require substantial supervision and direction due to Cognitive Impairment.

Independent Evaluation: We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and that the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

PART I BENEFITS

Limitations or Conditions on Eligibility for Benefits: All of the following conditions apply to the receipt of benefits.

1. You must qualify for benefits as set out in Part H.
2. You must receive care while confined in a Nursing Facility or Assisted Living Facility; or you must receive Home Health Care, Adult Day Care or Hospice Care, as defined.
3. The care received must be prescribed in your Plan of Care.
4. Your Plan of Care must be updated or recertified at least once every 90 days.
5. You must receive Covered Care in excess of the number of days shown in the Schedule as the Elimination Period.

When you are eligible for and receive Covered Care, we will pay the actual charges, up to the Daily Benefit Amount shown in the Schedule or in effect at the time you receive care. We will pay for each day you receive Covered Care. This benefit is subject to the Lifetime Maximum Benefit Period.

Covered Care: Care or services due to Injury or Sickness for which benefits are payable under this policy, or would have been payable except for any Elimination Period. This includes Nursing Facility Care, Assisted Living Facility Care, Home Health Care, Adult Day Care and Hospice Care.

Receipt of Multiple Covered Services on the Same Day: If you receive more than one type of covered service on the same day, the total amount we will pay for any one day will not exceed the Daily Benefit Amount.

PART J BED RESERVATION BENEFIT

Limitations or Conditions on Eligibility for Benefits: To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

1. You must be temporarily absent due to a Hospital confinement during the course of your covered stay in a Nursing Facility, Assisted Living Facility or Hospice Care Facility.

2. The Nursing Facility, Assisted Living Facility or Hospice Care Facility must charge you to keep your room available during your absence.

3. You must have satisfied any Elimination Period. If you have not, your days absent will not apply to the Elimination Period.

Benefit: When you meet the eligibility requirements of this provision we will pay a benefit. We will pay the actual charges of the Nursing Facility, Assisted Living Facility or Hospice Care Facility, up to the Daily Benefit Amount in effect at the time of the claim, to hold your room during your absence. We will pay this benefit for each day you are absent, up to 21 days per Benefit Period, subject to any Elimination Period and your Lifetime Maximum Benefit Period as described in Part E.

PART K RESTORATION OF LIFETIME MAXIMUM BENEFIT PERIOD

If you have received benefits under this policy and have used up all or a portion of the Lifetime Maximum Benefit Period shown in the Schedule, we will restore the policy's Lifetime Maximum Benefit Period, including any days used under the Bed Reservation Benefit, once during the lifetime of the policy if you meet the following qualifications:

1. You must not require or receive services for 180 days in a row for the same cause or causes for which a previous Benefit Period began;
2. You must not have met the requirements for benefit eligibility under the policy for a period of 180 days in a row; and
3. You must not have been (a) confined in a Nursing Facility, Assisted Living Care Facility or Hospice Care Facility; (b) received Home Health Care Services or Adult Day Care Services; or (c) any combination of (a) and (b) for a period of 180 days in a row.

The Lifetime Maximum Benefit Period will be restored only once during the lifetime of the policy; however, in order for the Lifetime Maximum Benefit Period to be restored, the policy must be kept in force by the continued payment of policy premiums that become due.

PART L HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days (60 days in Kentucky and Wyoming; six months in Montana) after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our Producers.

Claim Forms: When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable).

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART M PAYMENT OF CLAIMS

Time of Payment of Claims: Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid immediately upon receipt of your proof of loss. Benefits unpaid when our liability ends are paid immediately upon receipt of your proof of loss.

Payment of Claims: Benefits will be paid directly to you unless you assign your benefits. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000.00 ($5,000.00 in Kentucky and Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

Claim Review and Appeal Procedure: In the event of any claim denial with which you do not agree, you have the right to submit a written request to us at our Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days (15 days in Nebraska) after we receive that written request, we will notify you or your representative of the results of the review.

PART N OTHER POLICY PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: For a policy or certificate that has been in force for less than six months, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance for coverage.

For a policy or certificate that has been in force for at least six months, but less than two years, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a policy or certificate has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

The reinstated policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than 10 days after that date. In all other respects, you and we will have the same rights under this policy that you and we had before the date of lapse, subject to any provisions endorsed on or attached to the policy. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than sixty days prior to the date of reinstatement.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Misstatement of Age: If your age has been misstated, an adjustment in premiums, coverage or both will be made, based on your true age. No misstatement of age will continue insurance otherwise validly terminated, or terminate insurance otherwise validly in force.

Other Insurance With Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Extension of Benefits: Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Facility Care and Assisted Living Facility Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the payment of the Lifetime Maximum Benefit Period. It will be subject to the Elimination Period and all other applicable provisions of the policy.

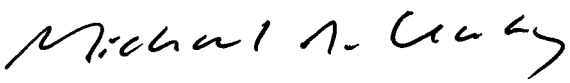
Refund of Premium Upon Your Death: Upon your death, we will return the premium for your coverage that was paid in advance beyond the end of the month in which your death occurred.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our President and Secretary sign this policy in our behalf.

President



Secretary

MEDICO INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NEBRASKA 68124

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A30

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

POLICY DATE ..... [11/01/10]
FIRST RENEWAL DATE ..... [11/01/00]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [62]

--- POLICY PREMIUMS---
[MODE] ……. $ [XXXX.XX]

ELIMINATION PERIOD ..... [0 DAYS]

DAILY BENEFIT AMOUNT ..... $ [100.00]

LIFETIME MAXIMUM BENEFIT PERIOD ..... [360 DAYS]

OPTIONAL RIDERS:

--[MODE]--

MIRA34 SURVIVORSHIP BENEFIT RIDER PREMIUM ..... $ [XXXX.XX]

MIRA38 INFLATION PROTECTION RIDER PREMIUM ..... $ [XXXX.XX]

TOTAL POLICY AND RIDER PREMIUM..... $ [XXXX.XX]

A30 POLICY SCHEDULE

MEDICO® INSURANCE COMPANY

1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER – XXXXXXX

TOLL-FREE CLIENT SERVICES

If you have any questions about your policy, you can call this Company's Toll-Free Client Services Line at 1-800-228-6080 between 7:30 A.M. and 4:45 P.M., Monday through Thursday; and 7:30 A.M. and 11:30 A.M. on Friday, Central Time.

If you prefer to write to us, please direct your letter to the Client Services Department, using the Company's name and address shown above.

Questions can also be directed to your producer. (Producer: Attach your business card below.)

In addition, you may submit written inquiries to:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

You may also call:

Arkansas Insurance Department
Consumer Services Division at
(800) 852-5494 or (501) 371-2640

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program SHIP.

– ENDORSEMENT –

MEDICO® INSURANCE COMPANY

1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER – XXXXXXX

SURVIVORSHIP BENEFIT RIDER

RIDER SCHEDULE

INSURED: «Insured»

RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): «RiderDate»

RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): «RiderPremium»

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word "policy" is changed to the word "rider."

BENEFIT

SURVIVING SPOUSE BENEFIT

Eligibility, Based on Death of an Insured's Spouse: To be eligible to receive this benefit, you must meet all of the conditions listed below:

1. Your spouse must have a Recovery Care Policy of this same form number with the same riders in force with us.
2. That policy must be applied for at the same time as yours, and issued with the same Policy Date.
3. Your coverage and that of your spouse must remain in continuous force for at least ten years after the Policy Date.
4. Your coverage and that of your spouse must remain in continuous force until the death of your spouse.

Benefit: If you meet the conditions listed above for eligibility, we will not require the payment of any further premium under this policy after the death of your spouse.

TERM OF COVERAGE: This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.

President

– ENDORSEMENT –

MEDICO® INSURANCE COMPANY

1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER – XXXXXXX

INFLATION PROTECTION RIDER

RIDER SCHEDULE

INSURED: «Insured»

RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): «RiderDate»

RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): «RiderPremium»

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word "policy" is changed to the word "rider."

BENEFIT

Your policy Schedule shows the Daily Benefit Amount. As long as the policy and this rider remain in force, the Daily Benefit Amount will automatically increase on the policy Anniversary Date. The amount of the increase will be 5% of the original Daily Benefit Amount. The Daily Benefit Amount will continue to increase for the life of the policy while this rider is in force. This rider will not increase the Lifetime Maximum Benefit Period.

TERM OF COVERAGE: This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.

President

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*43800*
Company Tracking Number:	*AR A30 RECOVERY CARE*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*AR A30 Recovery Care*		
Project Name/Number:	*AR A30 Recovery Care/LM AR A30 Recovery Care*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 10/27/2009	A30 Rates Individual	MI-NHA30(AR)	New		AR A30 rates as filed.pdf
Approved-Closed 10/27/2009	A30 Rates Association	MI-NHA30(AR)	New		AR A30G rates as filed.pdf

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 - Rate Group: A30
Recovery Care Policy

RATE SCHEDULE - Arkansas

ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Premium	240 Day BP 0Day EP Premium	360 Day BP 0Day EP Premium	120 Day BP 15Day EP Premium	240 Day BP 15Day EP Premium	360 Day BP 15Day EP Premium	120 Day BP 30Day EP Premium	240 Day BP 30Day EP Premium	360 Day BP 30Day EP Premium
18 - 54	16.82	25.77	35.48	14.80	23.19	32.64	14.13	22.16	31.22
55	17.65	26.88	37.19	15.53	24.19	34.22	14.82	23.12	32.73
56	18.53	28.42	39.43	16.31	25.58	36.28	15.57	24.44	34.70
57	19.46	30.17	41.95	17.12	27.16	38.60	16.35	25.95	36.92
58	20.46	32.20	44.83	18.00	28.98	41.24	17.18	27.69	39.45
59	21.60	34.56	48.15	19.01	31.10	44.30	18.14	29.72	42.37
60	22.97	37.33	52.01	20.22	33.59	47.85	19.30	32.10	45.77
61	24.67	40.56	56.50	21.71	36.51	51.98	20.72	34.88	49.72
62	26.77	44.34	61.73	23.56	39.90	56.79	22.49	38.13	54.32
63	29.34	48.68	67.73	25.82	43.81	62.31	24.64	41.87	59.60
64	32.25	53.52	74.37	28.38	48.17	68.42	27.09	46.03	65.45
65	35.35	58.75	81.49	31.11	52.87	74.97	29.70	50.52	71.71
66	38.50	64.24	88.89	33.88	57.82	81.78	32.34	55.25	78.22
67	41.55	69.90	96.41	36.56	62.91	88.69	34.90	60.12	84.84
68	44.41	75.70	103.98	39.08	68.13	95.66	37.30	65.10	91.50
69	47.33	81.96	112.06	41.65	73.76	103.10	39.75	70.49	98.61
70	50.61	89.08	121.22	44.54	80.18	111.52	42.51	76.61	106.67
71	54.58	97.48	132.03	48.03	87.73	121.47	45.84	83.83	116.18
72	59.54	107.56	145.06	52.39	96.80	133.45	50.01	92.50	127.65
73	65.71	119.58	160.70	57.82	107.63	147.84	55.19	102.84	141.41
74	72.92	133.28	178.57	64.17	119.95	164.28	61.25	114.62	157.14
75	80.92	148.23	198.12	71.21	133.41	182.27	67.97	127.48	174.34
76	89.44	164.01	218.79	78.71	147.61	201.28	75.13	141.05	192.53
77	98.23	180.21	240.01	86.44	162.19	220.81	82.51	154.98	211.21
78	107.87	198.01	263.30	94.93	178.21	242.23	90.61	170.29	231.70
79	118.47	217.57	288.84	104.25	195.82	265.73	99.51	187.11	254.18

AVAILABLE DISCOUNT:
When two or more persons from the same household
are issued policies at the same time,
a 10% discount is applied to the premium rates

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA34
Gross Premium Code: A34 - Rate Group: A30
Survivorship Benefit Rider
Rider Rates per $1 of Annual Premiums

RATE SCHEDULE - Arkansas

Issue Age	Premium
18 - 79	0.17

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA34(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 - Rate Group: A30
Inflation Protection Rider

RATE SCHEDULE - Arkansas

ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Premium	240 Day BP 0Day EP Premium	360 Day BP 0Day EP Premium	120 Day BP 15Day EP Premium	240 Day BP 15Day EP Premium	360 Day BP 15Day EP Premium	120 Day BP 30Day EP Premium	240 Day BP 30Day EP Premium	360 Day BP 30Day EP Premium
18 - 54	10.45	18.36	34.55	9.19	16.53	31.79	8.77	15.80	30.41
55	14.41	24.18	35.36	12.68	21.77	32.53	12.11	20.79	31.11
56	15.12	25.50	37.36	13.30	22.95	34.36	12.70	21.93	32.87
57	15.96	27.16	39.86	14.05	24.44	36.66	13.40	23.35	35.07
58	16.93	29.19	42.92	14.90	26.27	39.49	14.23	25.11	37.77
59	18.00	31.51	46.39	15.84	28.36	42.68	15.12	27.10	40.83
60	19.10	33.94	50.02	16.81	30.55	46.01	16.04	29.19	44.01
61	20.17	36.35	53.57	17.75	32.71	49.28	16.95	31.26	47.14
62	21.15	38.57	56.79	18.61	34.72	52.24	17.77	33.17	49.97
63	21.99	40.51	59.52	19.35	36.46	54.76	18.48	34.83	52.38
64	22.71	42.18	61.84	19.98	37.96	56.89	19.08	36.27	54.41
65	23.35	43.63	63.84	20.55	39.27	58.74	19.61	37.52	56.18
66	23.94	44.94	65.69	21.07	40.44	60.43	20.11	38.64	57.81
67	24.51	46.14	67.48	21.57	41.53	62.09	20.59	39.68	59.39
68	25.10	47.31	69.36	22.09	42.58	63.81	21.09	40.69	61.04
69	25.70	48.49	71.35	22.61	43.65	65.63	21.59	41.70	62.79
70	26.29	49.75	73.48	23.13	44.77	67.61	22.09	42.79	64.67
71	26.85	51.14	75.80	23.63	46.02	69.73	22.56	43.98	66.71
72	27.38	52.70	78.33	24.10	47.44	72.07	23.00	45.33	68.93
73	27.86	54.50	81.09	24.52	49.04	74.61	23.41	46.87	71.37
74	28.31	56.47	84.05	24.91	50.83	77.33	23.78	48.57	73.97
75	28.71	58.59	87.15	25.27	52.73	80.18	24.12	50.39	76.70
76	29.10	60.81	90.35	25.60	54.73	83.13	24.44	52.30	79.51
77	29.47	63.08	93.61	25.93	56.77	86.12	24.76	54.25	82.37
78	29.69	65.26	96.73	26.12	58.73	89.00	24.94	56.12	85.13
79	29.72	67.32	99.70	26.16	60.58	91.72	24.97	57.90	87.73

AVAILABLE DISCOUNT:
When two or more persons from the same household
are issued policies at the same time,
a 10% discount is applied to the premium rates

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 0Day EP Household Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 15Day EP Household Premium	120 Day BP 30Day EP Individual Premium	120 Day BP 30Day EP Household Premium
18 - 54	15.98	14.30	14.06	12.58	13.42	12.01
55	16.77	15.00	14.75	13.20	14.08	12.60
56	17.60	15.75	15.49	13.86	14.79	13.23
57	18.49	16.54	16.26	14.55	15.53	13.90
58	19.44	17.39	17.10	15.30	16.32	14.60
59	20.52	18.36	18.06	16.16	17.23	15.42
60	21.82	19.52	19.21	17.19	18.34	16.41
61	23.44	20.97	20.62	18.45	19.68	17.61
62	25.43	22.75	22.38	20.03	21.37	19.12
63	27.87	24.94	24.53	21.95	23.41	20.94
64	30.64	27.41	26.96	24.12	25.74	23.03
65	33.58	30.05	29.55	26.44	28.22	25.25
66	36.58	32.73	32.19	28.80	30.72	27.49
67	39.47	35.32	34.73	31.08	33.16	29.67
68	42.19	37.75	37.13	33.22	35.44	31.71
69	44.96	40.23	39.57	35.40	37.76	33.79
70	48.08	43.02	42.31	37.86	40.38	36.13
71	51.85	46.39	45.63	40.83	43.55	38.96
72	56.56	50.61	49.77	44.53	47.51	42.51
73	62.42	55.85	54.93	49.15	52.43	46.91
74	69.27	61.98	60.96	54.54	58.19	52.06
75	76.87	68.78	67.65	60.53	64.57	57.77
76	84.97	76.02	74.77	66.90	71.37	63.86
77	93.32	83.50	82.12	73.47	78.38	70.13
78	102.48	91.69	90.18	80.69	86.08	77.02
79	112.55	100.70	99.04	88.61	94.53	84.58

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 0Day EP Household Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 15Day EP Household Premium	120 Day BP 30Day EP Individual Premium	120 Day BP 30Day EP Household Premium
18 - 54	15.14	14.30	13.32	12.58	12.72	12.01
55	15.89	15.00	13.98	13.20	13.34	12.60
56	16.68	15.75	14.68	13.86	14.01	13.23
57	17.51	16.54	15.41	14.55	14.72	13.90
58	18.41	17.39	16.20	15.30	15.46	14.60
59	19.44	18.36	17.11	16.16	16.33	15.42
60	20.67	19.52	18.20	17.19	17.37	16.41
61	22.20	20.97	19.54	18.45	18.65	17.61
62	24.09	22.75	21.20	20.03	20.24	19.12
63	26.41	24.94	23.24	21.95	22.18	20.94
64	29.03	27.41	25.54	24.12	24.38	23.03
65	31.82	30.05	28.00	26.44	26.73	25.25
66	34.65	32.73	30.49	28.80	29.11	27.49
67	37.40	35.32	32.90	31.08	31.41	29.67
68	39.97	37.75	35.17	33.22	33.57	31.71
69	42.60	40.23	37.49	35.40	35.78	33.79
70	45.55	43.02	40.09	37.86	38.26	36.13
71	49.12	46.39	43.23	40.83	41.26	38.96
72	53.59	50.61	47.15	44.53	45.01	42.51
73	59.14	55.85	52.04	49.15	49.67	46.91
74	65.63	61.98	57.75	54.54	55.13	52.06
75	72.83	68.78	64.09	60.53	61.17	57.77
76	80.50	76.02	70.84	66.90	67.62	63.86
77	88.41	83.50	77.80	73.47	74.26	70.13
78	97.08	91.69	85.44	80.69	81.55	77.02
79	106.62	100.70	93.83	88.61	89.56	84.58

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 30Day EP Individual Premium
18 - 54	14.30	12.58	12.01
55	15.00	13.20	12.60
56	15.75	13.86	13.23
57	16.54	14.55	13.90
58	17.39	15.30	14.60
59	18.36	16.16	15.42
60	19.52	17.19	16.41
61	20.97	18.45	17.61
62	22.75	20.03	19.12
63	24.94	21.95	20.94
64	27.41	24.12	23.03
65	30.05	26.44	25.25
66	32.73	28.80	27.49
67	35.32	31.08	29.67
68	37.75	33.22	31.71
69	40.23	35.40	33.79
70	43.02	37.86	36.13
71	46.39	40.83	38.96
72	50.61	44.53	42.51
73	55.85	49.15	46.91
74	61.98	54.54	52.06
75	68.78	60.53	57.77
76	76.02	66.90	63.86
77	83.50	73.47	70.13
78	91.69	80.69	77.02
79	100.70	88.61	84.58

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 0Day EP Household Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 15Day EP Household Premium	240 Day BP 30Day EP Individual Premium	240 Day BP 30Day EP Household Premium
18 - 54	24.48	21.90	22.03	19.71	21.05	18.84
55	25.54	22.85	22.98	20.56	21.96	19.65
56	27.00	24.16	24.30	21.74	23.22	20.77
57	28.66	25.64	25.80	23.09	24.65	22.06
58	30.59	27.37	27.53	24.63	26.31	23.54
59	32.83	29.38	29.55	26.44	28.23	25.26
60	35.46	31.73	31.91	28.55	30.50	27.29
61	38.53	34.48	34.68	31.03	33.14	29.65
62	42.12	37.69	37.91	33.92	36.22	32.41
63	46.25	41.38	41.62	37.24	39.78	35.59
64	50.84	45.49	45.76	40.94	43.73	39.13
65	55.81	49.94	50.23	44.94	47.99	42.94
66	61.03	54.60	54.93	49.15	52.49	46.96
67	66.41	59.42	59.76	53.47	57.11	51.10
68	71.92	64.35	64.72	57.91	61.85	55.34
69	77.86	69.67	70.07	62.70	66.97	59.92
70	84.63	75.72	76.17	68.15	72.78	65.12
71	92.61	82.86	83.34	74.57	79.64	71.26
72	102.18	91.43	91.96	82.28	87.88	78.63
73	113.60	101.64	102.25	91.49	97.70	87.41
74	126.62	113.29	113.95	101.96	108.89	97.43
75	140.82	126.00	126.74	113.40	121.11	108.36
76	155.81	139.41	140.23	125.47	134.00	119.89
77	171.20	153.18	154.08	137.86	147.23	131.73
78	188.11	168.31	169.30	151.48	161.78	144.75
79	206.69	184.93	186.03	166.45	177.75	159.04

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 0Day EP Household Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 15Day EP Household Premium	240 Day BP 30Day EP Individual Premium	240 Day BP 30Day EP Household Premium
18 - 54	23.19	21.90	20.87	19.71	19.94	18.84
55	24.19	22.85	21.77	20.56	20.81	19.65
56	25.58	24.16	23.02	21.74	22.00	20.77
57	27.15	25.64	24.44	23.09	23.36	22.06
58	28.98	27.37	26.08	24.63	24.92	23.54
59	31.10	29.38	27.99	26.44	26.75	25.26
60	33.60	31.73	30.23	28.55	28.89	27.29
61	36.50	34.48	32.86	31.03	31.39	29.65
62	39.91	37.69	35.91	33.92	34.32	32.41
63	43.81	41.38	39.43	37.24	37.68	35.59
64	48.17	45.49	43.35	40.94	41.43	39.13
65	52.88	49.94	47.58	44.94	45.47	42.94
66	57.82	54.60	52.04	49.15	49.73	46.96
67	62.91	59.42	56.62	53.47	54.11	51.10
68	68.13	64.35	61.32	57.91	58.59	55.34
69	73.76	69.67	66.38	62.70	63.44	59.92
70	80.17	75.72	72.16	68.15	68.95	65.12
71	87.73	82.86	78.96	74.57	75.45	71.26
72	96.80	91.43	87.12	82.28	83.25	78.63
73	107.62	101.64	96.87	91.49	92.56	87.41
74	119.95	113.29	107.96	101.96	103.16	97.43
75	133.41	126.00	120.07	113.40	114.73	108.36
76	147.61	139.41	132.85	125.47	126.95	119.89
77	162.19	153.18	145.97	137.86	139.48	131.73
78	178.21	168.31	160.39	151.48	153.26	144.75
79	195.81	184.93	176.24	166.45	168.40	159.04

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 30Day EP Individual Premium
18 - 54	21.90	19.71	18.84
55	22.85	20.56	19.65
56	24.16	21.74	20.77
57	25.64	23.09	22.06
58	27.37	24.63	23.54
59	29.38	26.44	25.26
60	31.73	28.55	27.29
61	34.48	31.03	29.65
62	37.69	33.92	32.41
63	41.38	37.24	35.59
64	45.49	40.94	39.13
65	49.94	44.94	42.94
66	54.60	49.15	46.96
67	59.42	53.47	51.10
68	64.35	57.91	55.34
69	69.67	62.70	59.92
70	75.72	68.15	65.12
71	82.86	74.57	71.26
72	91.43	82.28	78.63
73	101.64	91.49	87.41
74	113.29	101.96	97.43
75	126.00	113.40	108.36
76	139.41	125.47	119.89
77	153.18	137.86	131.73
78	168.31	151.48	144.75
79	184.93	166.45	159.04

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 0Day EP Household Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 15Day EP Household Premium	360 Day BP 30Day EP Individual Premium	360 Day BP 30Day EP Household Premium
18 - 54	33.71	30.16	31.01	27.74	29.66	26.54
55	35.33	31.61	32.51	29.09	31.09	27.82
56	37.46	33.52	34.47	30.84	32.97	29.50
57	39.85	35.66	36.67	32.81	35.07	31.38
58	42.59	38.11	39.18	35.05	37.48	33.53
59	45.74	40.93	42.09	37.66	40.25	36.01
60	49.41	44.21	45.46	40.67	43.48	38.90
61	53.68	48.03	49.38	44.18	47.23	42.26
62	58.64	52.47	53.95	48.27	51.60	46.17
63	64.34	57.57	59.19	52.96	56.62	50.66
64	70.65	63.21	65.00	58.16	62.18	55.63
65	77.42	69.27	71.22	63.72	68.12	60.95
66	84.45	75.56	77.69	69.51	74.31	66.49
67	91.59	81.95	84.26	75.39	80.60	72.11
68	98.78	88.38	90.88	81.31	86.93	77.78
69	106.46	95.25	97.95	87.64	93.68	83.82
70	115.16	103.04	105.94	94.79	101.34	90.67
71	125.43	112.23	115.40	103.25	110.37	98.75
72	137.81	123.30	126.78	113.43	121.27	108.50
73	152.67	136.60	140.45	125.66	134.34	120.20
74	169.64	151.78	156.07	139.64	149.28	133.57
75	188.21	168.40	173.16	154.93	165.62	148.19
76	207.85	185.97	191.22	171.09	182.90	163.65
77	228.01	204.01	209.77	187.69	200.65	179.53
78	250.14	223.81	230.12	205.90	220.12	196.95
79	274.40	245.51	252.44	225.87	241.47	216.05

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 0Day EP Household Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 15Day EP Household Premium	360 Day BP 30Day EP Individual Premium	360 Day BP 30Day EP Household Premium
18 - 54	31.93	30.16	29.38	27.74	28.10	26.54
55	33.47	31.61	30.80	29.09	29.46	27.82
56	35.49	33.52	32.65	30.84	31.23	29.50
57	37.76	35.66	34.74	32.81	33.23	31.38
58	40.35	38.11	37.12	35.05	35.51	33.53
59	43.34	40.93	39.87	37.66	38.13	36.01
60	46.81	44.21	43.07	40.67	41.19	38.90
61	50.85	48.03	46.78	44.18	44.75	42.26
62	55.56	52.47	51.11	48.27	48.89	46.17
63	60.96	57.57	56.08	52.96	53.64	50.66
64	66.93	63.21	61.58	58.16	58.91	55.63
65	73.34	69.27	67.47	63.72	64.54	60.95
66	80.00	75.56	73.60	69.51	70.40	66.49
67	86.77	81.95	79.82	75.39	76.36	72.11
68	93.58	88.38	86.09	81.31	82.35	77.78
69	100.85	95.25	92.79	87.64	88.75	83.82
70	109.10	103.04	100.37	94.79	96.00	90.67
71	118.83	112.23	109.32	103.25	104.56	98.75
72	130.55	123.30	120.11	113.43	114.89	108.50
73	144.63	136.60	133.06	125.66	127.27	120.20
74	160.71	151.78	147.85	139.64	141.43	133.57
75	178.31	168.40	164.04	154.93	156.91	148.19
76	196.91	185.97	181.15	171.09	173.28	163.65
77	216.01	204.01	198.73	187.69	190.09	179.53
78	236.97	223.81	218.01	205.90	208.53	196.95
79	259.96	245.51	239.16	225.87	228.76	216.05

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA30
Gross Premium Code: A30 G - Rate Group: A30
Recovery Care Policy - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 30Day EP Individual Premium
18 - 54	30.16	27.74	26.54
55	31.61	29.09	27.82
56	33.52	30.84	29.50
57	35.66	32.81	31.38
58	38.11	35.05	33.53
59	40.93	37.66	36.01
60	44.21	40.67	38.90
61	48.03	44.18	42.26
62	52.47	48.27	46.17
63	57.57	52.96	50.66
64	63.21	58.16	55.63
65	69.27	63.72	60.95
66	75.56	69.51	66.49
67	81.95	75.39	72.11
68	88.38	81.31	77.78
69	95.25	87.64	83.82
70	103.04	94.79	90.67
71	112.23	103.25	98.75
72	123.30	113.43	108.50
73	136.60	125.66	120.20
74	151.78	139.64	133.57
75	168.40	154.93	148.19
76	185.97	171.09	163.65
77	204.01	187.69	179.53
78	223.81	205.90	196.95
79	245.51	225.87	216.05

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA30(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA34
Gross Premium Code: A34 G - Rate Group: A30
Survivorship Benefit Rider - Association Group
Rider Rates per $1 of Annual Premiums

RATE SCHEDULE - Arkansas

Issue Age	Premium
18 - 79	0.17

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA34(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 0Day EP Household Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 15Day EP Household Premium	120 Day BP 30Day EP Individual Premium	120 Day BP 30Day EP Household Premium
18 - 54	9.93	8.88	8.73	7.81	8.33	7.45
55	13.69	12.25	12.05	10.78	11.50	10.29
56	14.36	12.85	12.64	11.31	12.07	10.80
57	15.16	13.57	13.35	11.94	12.73	11.39
58	16.08	14.39	14.16	12.67	13.52	12.10
59	17.10	15.30	15.05	13.46	14.36	12.85
60	18.15	16.24	15.97	14.29	15.24	13.63
61	19.16	17.14	16.86	15.09	16.10	14.41
62	20.09	17.98	17.68	15.82	16.88	15.10
63	20.89	18.69	18.38	16.45	17.56	15.71
64	21.57	19.30	18.98	16.98	18.13	16.22
65	22.18	19.85	19.52	17.47	18.63	16.67
66	22.74	20.35	20.02	17.91	19.10	17.09
67	23.28	20.83	20.49	18.33	19.56	17.50
68	23.85	21.34	20.99	18.78	20.04	17.93
69	24.42	21.85	21.48	19.22	20.51	18.35
70	24.98	22.35	21.97	19.66	20.99	18.78
71	25.51	22.82	22.45	20.09	21.43	19.18
72	26.01	23.27	22.90	20.49	21.85	19.55
73	26.47	23.68	23.29	20.84	22.24	19.90
74	26.89	24.06	23.66	21.17	22.59	20.21
75	27.27	24.40	24.01	21.48	22.91	20.50
76	27.65	24.74	24.32	21.76	23.22	20.77
77	28.00	25.05	24.63	22.04	23.52	21.05
78	28.21	25.24	24.81	22.20	23.69	21.20
79	28.23	25.26	24.85	22.24	23.72	21.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 0Day EP Household Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 15Day EP Household Premium	120 Day BP 30Day EP Individual Premium	120 Day BP 30Day EP Household Premium
18 - 54	9.41	8.88	8.27	7.81	7.89	7.45
55	12.97	12.25	11.41	10.78	10.90	10.29
56	13.61	12.85	11.97	11.31	11.43	10.80
57	14.36	13.57	12.65	11.94	12.06	11.39
58	15.24	14.39	13.41	12.67	12.81	12.10
59	16.20	15.30	14.26	13.46	13.61	12.85
60	17.19	16.24	15.13	14.29	14.44	13.63
61	18.15	17.14	15.98	15.09	15.26	14.41
62	19.04	17.98	16.75	15.82	15.99	15.10
63	19.79	18.69	17.42	16.45	16.63	15.71
64	20.44	19.30	17.98	16.98	17.17	16.22
65	21.02	19.85	18.50	17.47	17.65	16.67
66	21.55	20.35	18.96	17.91	18.10	17.09
67	22.06	20.83	19.41	18.33	18.53	17.50
68	22.59	21.34	19.88	18.78	18.98	17.93
69	23.13	21.85	20.35	19.22	19.43	18.35
70	23.66	22.35	20.82	19.66	19.88	18.78
71	24.17	22.82	21.27	20.09	20.30	19.18
72	24.64	23.27	21.69	20.49	20.70	19.55
73	25.07	23.68	22.07	20.84	21.07	19.90
74	25.48	24.06	22.42	21.17	21.40	20.21
75	25.84	24.40	22.74	21.48	21.71	20.50
76	26.19	24.74	23.04	21.76	22.00	20.77
77	26.52	25.05	23.34	22.04	22.28	21.05
78	26.72	25.24	23.51	22.20	22.45	21.20
79	26.75	25.26	23.54	22.24	22.47	21.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	120 Day BP 0Day EP Individual Premium	120 Day BP 15Day EP Individual Premium	120 Day BP 30Day EP Individual Premium
18 - 54	8.88	7.81	7.45
55	12.25	10.78	10.29
56	12.85	11.31	10.80
57	13.57	11.94	11.39
58	14.39	12.67	12.10
59	15.30	13.46	12.85
60	16.24	14.29	13.63
61	17.14	15.09	14.41
62	17.98	15.82	15.10
63	18.69	16.45	15.71
64	19.30	16.98	16.22
65	19.85	17.47	16.67
66	20.35	17.91	17.09
67	20.83	18.33	17.50
68	21.34	18.78	17.93
69	21.85	19.22	18.35
70	22.35	19.66	18.78
71	22.82	20.09	19.18
72	23.27	20.49	19.55
73	23.68	20.84	19.90
74	24.06	21.17	20.21
75	24.40	21.48	20.50
76	24.74	21.76	20.77
77	25.05	22.04	21.05
78	25.24	22.20	21.20
79	25.26	22.24	21.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 0Day EP Household Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 15Day EP Household Premium	240 Day BP 30Day EP Individual Premium	240 Day BP 30Day EP Household Premium
18 - 54	17.44	15.61	15.70	14.05	15.01	13.43
55	22.97	20.55	20.68	18.50	19.75	17.67
56	24.23	21.68	21.80	19.51	20.83	18.64
57	25.80	23.09	23.22	20.77	22.18	19.85
58	27.73	24.81	24.96	22.33	23.85	21.34
59	29.93	26.78	26.94	24.11	25.75	23.04
60	32.24	28.85	29.02	25.97	27.73	24.81
61	34.53	30.90	31.07	27.80	29.70	26.57
62	36.64	32.78	32.98	29.51	31.51	28.19
63	38.48	34.43	34.64	30.99	33.09	29.61
64	40.07	35.85	36.06	32.27	34.46	30.83
65	41.45	37.09	37.31	33.38	35.64	31.89
66	42.69	38.20	38.42	34.37	36.71	32.84
67	43.83	39.22	39.45	35.30	37.70	33.73
68	44.94	40.21	40.45	36.19	38.66	34.59
69	46.07	41.22	41.47	37.10	39.62	35.45
70	47.26	42.29	42.53	38.05	40.65	36.37
71	48.58	43.47	43.72	39.12	41.78	37.38
72	50.07	44.80	45.07	40.32	43.06	38.53
73	51.78	46.33	46.59	41.68	44.53	39.84
74	53.65	48.00	48.29	43.21	46.14	41.28
75	55.66	49.80	50.09	44.82	47.87	42.83
76	57.77	51.69	51.99	46.52	49.69	44.46
77	59.93	53.62	53.93	48.25	51.54	46.11
78	62.00	55.47	55.79	49.92	53.31	47.70
79	63.95	57.22	57.55	51.49	55.01	49.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 0Day EP Household Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 15Day EP Household Premium	240 Day BP 30Day EP Individual Premium	240 Day BP 30Day EP Household Premium
18 - 54	16.52	15.61	14.88	14.05	14.22	13.43
55	21.76	20.55	19.59	18.50	18.71	17.67
56	22.95	21.68	20.66	19.51	19.74	18.64
57	24.44	23.09	22.00	20.77	21.02	19.85
58	26.27	24.81	23.64	22.33	22.60	21.34
59	28.36	26.78	25.52	24.11	24.39	23.04
60	30.55	28.85	27.50	25.97	26.27	24.81
61	32.72	30.90	29.44	27.80	28.13	26.57
62	34.71	32.78	31.25	29.51	29.85	28.19
63	36.46	34.43	32.81	30.99	31.35	29.61
64	37.96	35.85	34.16	32.27	32.64	30.83
65	39.27	37.09	35.34	33.38	33.77	31.89
66	40.45	38.20	36.40	34.37	34.78	32.84
67	41.53	39.22	37.38	35.30	35.71	33.73
68	42.58	40.21	38.32	36.19	36.62	34.59
69	43.64	41.22	39.29	37.10	37.53	35.45
70	44.78	42.29	40.29	38.05	38.51	36.37
71	46.03	43.47	41.42	39.12	39.58	37.38
72	47.43	44.80	42.70	40.32	40.80	38.53
73	49.05	46.33	44.14	41.68	42.18	39.84
74	50.82	48.00	45.75	43.21	43.71	41.28
75	52.73	49.80	47.46	44.82	45.35	42.83
76	54.73	51.69	49.26	46.52	47.07	44.46
77	56.77	53.62	51.09	48.25	48.83	46.11
78	58.73	55.47	52.86	49.92	50.51	47.70
79	60.59	57.22	54.52	51.49	52.11	49.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	240 Day BP 0Day EP Individual Premium	240 Day BP 15Day EP Individual Premium	240 Day BP 30Day EP Individual Premium
18 - 54	15.61	14.05	13.43
55	20.55	18.50	17.67
56	21.68	19.51	18.64
57	23.09	20.77	19.85
58	24.81	22.33	21.34
59	26.78	24.11	23.04
60	28.85	25.97	24.81
61	30.90	27.80	26.57
62	32.78	29.51	28.19
63	34.43	30.99	29.61
64	35.85	32.27	30.83
65	37.09	33.38	31.89
66	38.20	34.37	32.84
67	39.22	35.30	33.73
68	40.21	36.19	34.59
69	41.22	37.10	35.45
70	42.29	38.05	36.37
71	43.47	39.12	37.38
72	44.80	40.32	38.53
73	46.33	41.68	39.84
74	48.00	43.21	41.28
75	49.80	44.82	42.83
76	51.69	46.52	44.46
77	53.62	48.25	46.11
78	55.47	49.92	47.70
79	57.22	51.49	49.22

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 0Day EP Household Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 15Day EP Household Premium	360 Day BP 30Day EP Individual Premium	360 Day BP 30Day EP Household Premium
18 - 54	32.82	29.37	30.20	27.02	28.89	25.85
55	33.59	30.06	30.90	27.65	29.55	26.44
56	35.49	31.76	32.64	29.21	31.23	27.94
57	37.87	33.88	34.83	31.16	33.32	29.81
58	40.77	36.48	37.52	33.57	35.88	32.10
59	44.07	39.43	40.55	36.28	38.79	34.71
60	47.52	42.52	43.71	39.11	41.81	37.41
61	50.89	45.53	46.82	41.89	44.78	40.07
62	53.95	48.27	49.63	44.40	47.47	42.47
63	56.54	50.59	52.02	46.55	49.76	44.52
64	58.75	52.56	54.05	48.36	51.69	46.25
65	60.65	54.26	55.80	49.93	53.37	47.75
66	62.41	55.84	57.41	51.37	54.92	49.14
67	64.11	57.36	58.99	52.78	56.42	50.48
68	65.89	58.96	60.62	54.24	57.99	51.88
69	67.78	60.65	62.35	55.79	59.65	53.37
70	69.81	62.46	64.23	57.47	61.44	54.97
71	72.01	64.43	66.24	59.27	63.37	56.70
72	74.41	66.58	68.47	61.26	65.48	58.59
73	77.04	68.93	70.88	63.42	67.80	60.66
74	79.85	71.44	73.46	65.73	70.27	62.87
75	82.79	74.08	76.17	68.15	72.87	65.20
76	85.83	76.80	78.97	70.66	75.53	67.58
77	88.93	79.57	81.81	73.20	78.25	70.01
78	91.89	82.22	84.55	75.65	80.87	72.36
79	94.72	84.75	87.13	77.96	83.34	74.57

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 0Day EP Household Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 15Day EP Household Premium	360 Day BP 30Day EP Individual Premium	360 Day BP 30Day EP Household Premium
18 - 54	31.10	29.37	28.61	27.02	27.37	25.85
55	31.82	30.06	29.28	27.65	28.00	26.44
56	33.62	31.76	30.92	29.21	29.58	27.94
57	35.87	33.88	32.99	31.16	31.56	29.81
58	38.63	36.48	35.54	33.57	33.99	32.10
59	41.75	39.43	38.41	36.28	36.75	34.71
60	45.02	42.52	41.41	39.11	39.61	37.41
61	48.21	45.53	44.35	41.89	42.43	40.07
62	51.11	48.27	47.02	44.40	44.97	42.47
63	53.57	50.59	49.28	46.55	47.14	44.52
64	55.66	52.56	51.20	48.36	48.97	46.25
65	57.46	54.26	52.87	49.93	50.56	47.75
66	59.12	55.84	54.39	51.37	52.03	49.14
67	60.73	57.36	55.88	52.78	53.45	50.48
68	62.42	58.96	57.43	54.24	54.94	51.88
69	64.22	60.65	59.07	55.79	56.51	53.37
70	66.13	62.46	60.85	57.47	58.20	54.97
71	68.22	64.43	62.76	59.27	60.04	56.70
72	70.50	66.58	64.86	61.26	62.04	58.59
73	72.98	68.93	67.15	63.42	64.23	60.66
74	75.65	71.44	69.60	65.73	66.57	62.87
75	78.44	74.08	72.16	68.15	69.03	65.20
76	81.32	76.80	74.82	70.66	71.56	67.58
77	84.25	79.57	77.51	73.20	74.13	70.01
78	87.06	82.22	80.10	75.65	76.62	72.36
79	89.73	84.75	82.55	77.96	78.96	74.57

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

Medico™ Insurance Company
Omaha, Nebraska
MI-NHA38
Gross Premium Code: A38 G - Rate Group: A30
Inflation Protection Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%
ANNUAL PREMIUMS PER $10 DAILY BENEFIT

Issue Age	360 Day BP 0Day EP Individual Premium	360 Day BP 15Day EP Individual Premium	360 Day BP 30Day EP Individual Premium
18 - 54	29.37	27.02	25.85
55	30.06	27.65	26.44
56	31.76	29.21	27.94
57	33.88	31.16	29.81
58	36.48	33.57	32.10
59	39.43	36.28	34.71
60	42.52	39.11	37.41
61	45.53	41.89	40.07
62	48.27	44.40	42.47
63	50.59	46.55	44.52
64	52.56	48.36	46.25
65	54.26	49.93	47.75
66	55.84	51.37	49.14
67	57.36	52.78	50.48
68	58.96	54.24	51.88
69	60.65	55.79	53.37
70	62.46	57.47	54.97
71	64.43	59.27	56.70
72	66.58	61.26	58.59
73	68.93	63.42	60.66
74	71.44	65.73	62.87
75	74.08	68.15	65.20
76	76.80	70.66	67.58
77	79.57	73.20	70.01
78	82.22	75.65	72.36
79	84.75	77.96	74.57

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52000
Quarterly = 0.27000
Bi-Monthly = 0.18182
Monthly = 0.09091

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 6/12
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 60% anticipated loss ratio.

MIRSA38(AR) 10/09

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*43800*
Company Tracking Number:	*AR A30 RECOVERY CARE*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*AR A30 Recovery Care*		
Project Name/Number:	*AR A30 Recovery Care/LM AR A30 Recovery Care*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/27/2009

Comments:

Attachment:

AR Flesch Certificate MIC.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/27/2009

Comments:

A copy of applications, MIHAA30(AR) and MIHAA30(AR)-A are enclosed for your approval. The only difference between MIHAA30(AR) and MIHAA30(AR)-A is that MIHAA30(AR)-A, Part D, has reference to an association discount and asks for the association name and member name and member identification number. Otherwise, the two forms are identical.

Attachments:

MIHAA30(AR)-10122009.pdf

MIHAA30(AR)-A-10122009.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	10/27/2009

Comments:

Attachment:

MI9F-4356(AR)-10122009.pdf

		Item Status:	Status Date:
Satisfied - Item:	MI9F-2701(AR)	Approved-Closed	10/27/2009

Comments:

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 and is enclosed here for informational purposes, only.

Attachment:

MI9F-2701(AR)-07012007.pdf

SERFF Tracking Number:	*MDIC-126340784*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*43800*
Company Tracking Number:	*AR A30 RECOVERY CARE*		
TOI:	*H13I Individual Health - Short Term Care*	*Sub-TOI:*	*H13I.002 Nursing Home*
Product Name:	*AR A30 Recovery Care*		
Project Name/Number:	*AR A30 Recovery Care/LM AR A30 Recovery Care*		

		Item Status:	**Status Date:**
Satisfied - Item:	MI9F-1060	Approved-Closed	10/27/2009

Comments:

MI9F-1060 Replacement Notice will be used when required by state law. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 and is enclosed here for informational purposes, only.

Attachment:

MI9F-1060-11032006.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	MI9F-4218	Approved-Closed	10/27/2009

Comments:

The medical authorization MI9F-4218 version 11262007 will be sent with the application to obtain medical authorization from the applicant. This HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

Attachment:

MI9F-4218-11262007.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	AR Cover Letter	Approved-Closed	10/27/2009

Comments:

Attachment:

AR Cover Letter.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	AR Filing Fee Certification	Approved-Closed	10/27/2009

Comments:

Attachment:

AR Filing Fee Certification.pdf

FLESCH READABILITY CERTIFICATION

Form Number MI-NHA30(AR) has been Flesch tested.
The Flesch Readability Score was computed to be 45.7.

Form Number MIRA34 has been Flesch tested.
The Flesch Readability Score was computed to be 64.2.

Form Number MIRA38 has been Flesch tested.
The Flesch Readability Score was computed to be 56.4.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

MEDICO INSURANCE COMPANY

Desiree Buckley

Desiree Buckley
Vice President, Director of Compliance

MEDICO®
INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

Application for Recovery Care Insurance Policy MI-NHA30

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Name _____ _____ ____ ____ ____ ____
First MI Last Date of Birth Mo./Day/Yr. Age Sex Height Weight

Address _____
Street Address City State Zip

Social Security # _____ Are you covered by Medicare? ❒ Yes ❒ No

If "Yes," give month and year you first enrolled in Medicare Part B _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ❒ Yes ❒ No

If "Yes," show replacement date _____ If "Yes," show name of company _____

Phone # _____ E-mail Address _____

Best time to call for Personal Health Interview _____

Beneficiary _____ Relationship _____ Address _____

Part B: Medical Information

QUALIFYING INFORMATION (If any answer to questions 1 through 11 is "YES," you are not eligible for coverage.)

Please answer the following questions to the best of your knowledge. In the past 24 months have you:

1. required assistance or supervision of any kind to perform daily activities such as walking, eating, bathing, dressing, toileting, transferring, maintaining continence, laundry, housekeeping, meal preparation, shopping or managing your finances or medications? ❒ Yes ❒ No
2. needed the assistance of a brace, walker, wheelchair, multi-pronged cane, crutches, stair lift, chair lift, motorized cart, hospital bed or oxygen? ❒ Yes ❒ No
3. been confined (or has any doctor recommended that you be confined) to a rehabilitation facility, nursing facility or assisted living facility; or have you received home health care services? ❒ Yes ❒ No
4. been diagnosed as having internal cancer or metastatic cancer? ❒ Yes ❒ No
5. had kidney disease requiring dialysis, insulin-dependent diabetes, diabetic neuropathy, diabetic retinopathy or liver disease? ❒ Yes ❒ No
6. had Parkinson's disease, any disease or disorder of the nervous system, senile dementia, Alzheimer's disease, psychotic disorders or memory loss? ❒ Yes ❒ No
7. had Lou Gehrig's disease (ALS), motor neuron disease, Huntington's chorea, multiple sclerosis, paralysis or amputation of a limb due to a disease? ❒ Yes ❒ No
8. been treated for heart attack, stroke, congestive heart failure or received any procedure to improve coronary circulation? ❒ Yes ❒ No
9. had more than one stroke, TIA or mini-stroke or fractures due to osteoporosis? ❒ Yes ❒ No

Part B: Medical Information, continued

10. been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) or have you been diagnosed has having the HIV virus as indicated by the results of the ELISA-ELISA Western Blot test series? ❒ Yes ❒ No

11. been treated for alcohol or drug abuse? ❒ Yes ❒ No

12. Are you currently taking any prescription medications?

    If "Yes," what prescription medications are you now taking?_____

    _____

    Primary or Family Physician_____ Telephone (____)_____

    Address_____

    Date of last visit with this physician_____ Reason for visit_____

    _____

Part C: Benefit Options for Recovery Care Policy Form MI-NHA30

Elimination Period Options: ❒ 0 Days ❒ 15 Days ❒ 30 Days

Daily Benefit Amount ($100 to $[300] in $10 increments): $_____

Lifetime Maximum Benefit Period Options: ❒ 120 Days ❒ 240 Days ❒ 360 Days

Optional Riders: ❒ MIRA34 Survivorship Benefit Rider ❒ MIRA38 Inflation Protection Rider

Part D: Payment Options

❒ Household Discount – If eligible, list name(s) of the other person or persons in your household who is/are also applying for this policy: _____

Make all checks payable to: Medico Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment:	**Mode - Frequency of Payment:**			
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Bi-Monthly	❒ Quarterly	
❒ Direct Bill	❒ Bi-Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Note: If you select the Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your bank account on the day we issue your policy.

Premium Calculation:

Policy Premium with or without Inflation Protection Rider premium - $_____ X number of units (10-30) _____ = $_____

If MIRA34 Survivorship Benefit Rider selected, X 1.17 and enter amount (skip this step if MIRA34 Rider not selected) $_____

If paying a mode other than Monthly Bank Withdrawal or Annual Direct Bill, multiply by the modal factor $_____

Amount Received with Application $_____ Renewal Premium $_____

Requested Effective Date of Policy (optional) _____
(Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the Effective Date will be the day after the applicant signs the application.)

Part E: Application Agreement

I hereby apply to Medico Insurance Company for a **Recovery Care Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

❒ 3. I am not eligible for Medicare.

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: ❒ Applicant ❒ Producer

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or, if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I acknowledge that in states where it is required, the producer met with me on this date, made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Recovery Care insurance.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____

MEDICO®
INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

Application for Recovery Care Insurance Policy MI-NHA30

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Name _____ _____ ____ ____ _____ _____
First MI Last Date of Birth Mo./Day/Yr. Age Sex Height Weight

Address _____
Street Address City State Zip

Social Security # _____ Are you covered by Medicare? ❒ Yes ❒ No

If "Yes," give month and year you first enrolled in Medicare Part B _____

Do you intend to replace any of your medical or health insurance coverage with this policy? ❒ Yes ❒ No

If "Yes," show replacement date _____ If "Yes," show name of company _____

Phone # _____ E-mail Address _____

Best time to call for Personal Health Interview _____

Beneficiary _____ Relationship _____ Address _____

Part B: Medical Information

QUALIFYING INFORMATION (If any answer to questions 1 through 11 is "YES," you are not eligible for coverage.)

Please answer the following questions to the best of your knowledge. In the past 24 months have you:

1. required assistance or supervision of any kind to perform daily activities such as walking, eating, bathing, dressing, toileting, transferring, maintaining continence, laundry, housekeeping, meal preparation, shopping or managing your finances or medications? ❒ Yes ❒ No
2. needed the assistance of a brace, walker, wheelchair, multi-pronged cane, crutches, stair lift, chair lift, motorized cart, hospital bed or oxygen? ❒ Yes ❒ No
3. been confined (or has any doctor recommended that you be confined) to a rehabilitation facility, nursing facility or assisted living facility; or have you received home health care services? ❒ Yes ❒ No
4. been diagnosed as having internal cancer or metastatic cancer? ❒ Yes ❒ No
5. had kidney disease requiring dialysis, insulin-dependent diabetes, diabetic neuropathy, diabetic retinopathy or liver disease? ❒ Yes ❒ No
6. had Parkinson's disease, any disease or disorder of the nervous system, senile dementia, Alzheimer's disease, psychotic disorders or memory loss? ❒ Yes ❒ No
7. had Lou Gehrig's disease (ALS), motor neuron disease, Huntington's chorea, multiple sclerosis, paralysis or amputation of a limb due to a disease? ❒ Yes ❒ No
8. been treated for heart attack, stroke, congestive heart failure or received any procedure to improve coronary circulation? ❒ Yes ❒ No
9. had more than one stroke, TIA or mini-stroke or fractures due to osteoporosis? ❒ Yes ❒ No

Part B: Medical Information, continued

10. been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC) or have you been diagnosed has having the HIV virus as indicated by the results of the ELISA-ELISA Western Blot test series? ❒ Yes ❒ No

11. been treated for alcohol or drug abuse? ❒ Yes ❒ No

12. Are you currently taking any prescription medications?

    If "Yes," what prescription medications are you now taking?_____

    _____

    Primary or Family Physician_____ Telephone (____)_____

    Address_____

    Date of last visit with this physician_____ Reason for visit_____

    _____

Part C: Benefit Options for Recovery Care Policy Form MI-NHA30

Elimination Period Options: ❒ 0 Days ❒ 15 Days ❒ 30 Days

Daily Benefit Amount ($100 to $[300] in $10 increments): $_____

Lifetime Maximum Benefit Period Options: ❒ 120 Days ❒ 240 Days ❒ 360 Days

Optional Riders: ❒ MIRA34 Survivorship Benefit Rider ❒ MIRA38 Inflation Protection Rider

Part D: Payment Options

❒ Household Discount – If eligible, list name(s) of the other person or persons in your household who is/are also applying for this policy: _____

❒ Association Discount Association Name:_____

Member Name:_____ Member Identification Number:_____

Make all checks payable to: Medico Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: **Mode - Frequency of Payment:**

❒ Automatic Bank Withdrawal ❒ Monthly ❒ Bi-Monthly ❒ Quarterly

❒ Direct Bill ❒ Bi-Monthly ❒ Quarterly ❒ Semi-Annually ❒ Annually

Note: If you select the Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your bank account on the day we issue your policy.

Premium Calculation:

Policy Premium with or without Inflation Protection Rider premium - $_____ X number of units (10-30) _____ = $_____

If MIRA34 Survivorship Benefit Rider selected, X 1.17 and enter amount (skip this step if MIRA34 Rider not selected) $_____

If paying a mode other than Monthly Bank Withdrawal or Annual Direct Bill, multiply by the modal factor $_____

Amount Received with Application $_____ Renewal Premium $_____

Requested Effective Date of Policy (optional) _____
(Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the Effective Date will be the day after the applicant signs the application.)

Part E: Application Agreement

I hereby apply to Medico Insurance Company for a **Recovery Care Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

❒ 3. I am not eligible for Medicare.

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: ❒ Applicant ❒ Producer

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or, if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I acknowledge that in states where it is required, the producer met with me on this date, made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Recovery Care insurance.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____

MEDICO® INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Policy MI-NHA30
Recovery Care Insurance

RECOVERY CARE

1. READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the policy. This is not the insurance contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and your insurance company. It is important that you **READ YOUR POLICY CAREFULLY!**

2. Terms Under Which the Policy May Be Continued In Force or Discontinued

   a. Renewability — Guaranteed Renewable — This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums on time.

   b. Terms Under Which We May Change Premiums — We can change premiums only if we do the same to all policies of this form, or optional riders attached to the policy, which are issued to persons of your class in your state, and we notify you in advance of the due date.

3. Short-Term Care Coverage — Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a Hospital, such as in a Nursing Facility or Assisted Living Facility. It is subject to limitations, Elimination Periods and other requirements.

NOTICE TO BUYER: **The policy may not cover all of the costs incurred by the buyer during the period of coverage. The buyer is advised to carefully review all policy limitations.**

4. Benefits Provided by This Policy

   a. Daily Benefit Amount: The amount we pay for Covered Care during one calendar day. You may choose from $100 to [$300] in $10 increments: $_____

   Lifetime Maximum Benefit Period: The maximum period for which we will pay benefits during your lifetime under the policy. You may choose from:

   ☐ 120-Day Lifetime Maximum Benefit Period

   ☐ 240-Day Lifetime Maximum Benefit Period

   ☐ 360-Day Lifetime Maximum Benefit Period

   Elimination Period: The number of days for which no benefits are payable. The Elimination Period starts on the date that benefits would otherwise begin. Only days in which services are actually rendered will satisfy your Elimination Period. You will only be required to satisfy one Elimination Period per Benefit Period. You may choose from:

   ☐ 0 Days per Benefit Period ☐ 15 Days per Benefit Period ☐ 30 Days per Benefit Period

LIMITED BENEFIT POLICY
FOR NURSING FACILITY CARE, ASSISTED LIVING FACILITY CARE, HOME HEALTH CARE,
ADULT DAY CARE AND HOSPICE CARE
THIS IS NOT A LONG-TERM CARE POLICY

b. Eligibility for Payment of Benefits — To be eligible for any benefit under the policy, your Physician or your Licensed Health Care Practitioner must show that you meet one of the following benefit qualifiers:

(1) Loss of Functional Capacity: You need active Substantial Assistance to perform at least two of the six Activities of Daily Living. The "Activities of Daily Living" are: (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence; and (f) bathing.

(2) Cognitive Impairment: You require substantial supervision and direction due to Cognitive Impairment.

A prior hospital stay is not a requirement for benefit eligibility. Benefits begin after you have satisfied the Elimination Period. Benefits are subject to your Lifetime Maximum Benefit Period. The facility or agency must be licensed by the state and it must provide Covered Care. The care received must be prescribed in your Plan of Care, and your Plan of Care must be recertified by your Physician every 90 days.

c. Benefits — The policy pays the actual charges, up to the Daily Benefit Amount in effect at the time of service for each day you receive Covered Care while confined in a Nursing Facility or Assisted Living Facility, or that you receive Home Health Care, Adult Day Care or Hospice Care.

Covered Care: Care or services due to Injury or Sickness for which benefits are payable under this policy, or would have been payable except for any Elimination Period. This includes Nursing Facility Care, Assisted Living Facility Care, Home Health Care, Adult Day Care and Hospice Care.

d. Bed Reservation Benefit — If you are temporarily absent due to a Hospital confinement during the course of your covered stay in a Nursing Facility, Assisted Living Facility or Hospice Care Facility, we will pay the actual charges of the facility, up to the Daily Benefit Amount in effect at the time of the claim, to hold your room in your absence.

We will only pay if the facility charges you to keep your room available in your absence. We will pay this benefit up to 21 days per Benefit Period, subject to any Elimination Period and your Lifetime Maximum Benefit Period.

e. Restoration of Lifetime Maximum Benefit Period — If you have received benefits under this policy and have used up all or a portion of the Lifetime Maximum Benefit Period, we will restore the policy's Lifetime Maximum Benefit Period, including any days used under the Bed Reservation Benefit, once during the lifetime of the policy when (1) you no longer require or receive services for 180 days in a row for the same cause or causes for which a previous Benefit Period began; (2) you do not meet the requirements for benefit eligibility under the policy for a period of 180 days in a row; and (3) you have not been (a) confined in a Nursing Facility, Assisted Living Care Facility or Hospice Care Facility; (b) received Home Health Care Services or Adult Day Care Services; or (c) any combination of (a) and (b) for a period of 180 days in a row.

The restoration will only take place if your policy is kept in force by the continued payment of premiums that come due.

f. Optional Survivorship Benefit Rider (Rider Form MIRA34) — If (1) your spouse has a Recovery Care Policy of the same form number with the same riders in force with us; (2) your spouse's policy was applied for at the same time as yours, and issued with the same Policy Date; (3) your coverage and that of your spouse remain in continuous force for at least 10 years after the Policy Date; and (4) your coverage and that of your spouse remain in continuous force until the death of your spouse; we will not require the payment of any further premium under this policy after the death of your spouse.

g. Optional Inflation Protection Rider (Rider Form MIRA38) — The rider automatically increases your Daily Benefit Amount by 5% of the original Daily Benefit Amount annually on each policy Anniversary Date.

5. Limitations and Exclusions

a. Exceptions — We will NOT pay benefits for: (1) loss that occurs while this coverage is not in force; (2) intentional, self-inflicted injury or attempted suicide (in Colorado and Missouri, while sane); (3) Mental or Nervous Disorders without demonstrable organic disease **(subject to the other policy provisions, we will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the policy);** (4) alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician; (5) injuries received or caused in consequence of your being intoxicated or under the influence of any controlled substance, unless administered on the advice of a Physician; (6) loss to which a contributing cause was your commission of or attempt to commit a felony or to which a contributing cause was your being engaged in an illegal occupation; (7) care or services provided by a member of your Immediate Family; (8) services for which you are not liable or for which no charge normally is made in the absence of insurance; (9) loss that occurs outside the territorial limits of the United States; and (10) drugs or supplies.

b. Pre-Existing Conditions Limitation — We will not cover any loss or confinement due to a pre-existing condition if the loss occurs or the confinement begins within the first 180 days (6 months) after your Policy Date. A pre-existing condition means a condition for which a prudent person would seek medical advice or treatment, or for which medical advice was given or treatment was received from a Licensed Health Care Practitioner within six months before your Policy Date.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR RECOVERY CARE NEEDS.

6. Premium

Automatic Bank Withdrawal:

Monthly	Bi-Monthly	Quarterly

Direct Bill:

Bi-Monthly	Quarterly	Semi-Annually	Annually

Premiums are subject to change on a limited basis, as stated above in the Renewal Agreement. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.

Printed Name of Producer (if any):_____
First Middle Initial Last

Address:_____
Street Address, Rural Route or Box Number

_____
City State Zip Code

_____ _____/_____
Date Home Office Employee/Producer

If you have any questions about this policy, please write or call us toll-free at 1-800-228-6080.

MEDICO™ INSURANCE COMPANY
Omaha, Nebraska

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
425 W. Capitol Ave.
Suite 3700
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

MEDICO® INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

_____
(Agent's Signature)

MEDICO® GROUP

Medico Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy/certificate.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

_____
Printed Name of Applicant/Insured

_____ _____
Signature of Applicant/Insured Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

_____ _____
Printed Name of Personal Representative Description of Personal Representative's Authority

_____ _____
Signature of Personal Representative Date

MEDICO® GROUP
Medico® Insurance Company

October 15, 2009

MEDICO INSURANCE COMPANY
NAIC # 31119

Commissioner Jay Bradford
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Individual Recovery Care Policy

Enclosed Material:

MI-NHA30(AR) – Policy
A30 Schedule – Policy Schedule
MI9F-4356(AR) – Outline of Coverage
MIHAA30(AR) – Application
MIHAA30(AR)-A – Application
MIRA34 – Survivorship Benefit Rider
MIRA38 – Inflation Protection Rider (simple)
MI9F-4185RC – Medicare Duplication Notice
MIR-AR-763 – Toll-Free Customer Service Notice
Actuarial Memorandum and rate sheets
Filing Forms

Previously Approved/Filed Form:

MI9F-1060 – Replacement Notice
MI9F-2701(AR) – Guaranty Association Notice

Informational Form:

MI9F-4218 -HIPPA Compliant Medical Authorization

Enclosed, you will find Recovery Care Policy and accompanying forms for your approval. These new forms will not replace any forms currently on file with your Department.

The MI-NHA30(AR) Recovery Care form is a new policy providing benefits for Nursing Facility, Assisted Living Facility, Home Health Care, Adult Day Care and Hospice Care. The applicant will be able to select from three elimination periods; 0, 15 or 30 days. The daily benefit ranges from $100 to $300 in $10 increments, at this time. We have filed rates for up to $400 for future use. The Application, Outline of Coverage and marketing materials, etc. have been filed with brackets so we can change these amounts at a later date. The policy also has three options for the Lifetime Maximum Benefit Period; 120 days, 240 days or 360 days.

The applicant will have the option to select two riders for additional cost, MIRA34 Survivorship Benefit Rider and MIRA38 Inflation Protection Rider (simple). These optional riders add additional benefits to the base policy. The two optional riders are enclosed your review and approval.

We intend to offer this new policy through our producers to eligible individuals who are ages 18 through 79. An A30 sample schedule is attached. Any information contained in the brackets will vary to fit each policyholder.

The outline of coverage MI9F-4356(AR) will be furnished to each applicant as required by state law.

A copy of applications, MIHAA30(AR) and MIHAA30(AR)-A are enclosed for your approval. The only difference between MIHAA30(AR) and MIHAA30(AR)-A is that MIHAA30(AR)-A, Part D, has reference to an association discount and asks for the association name and member name and member identification number. Otherwise, the two forms are identical.

The medical authorization MI9F-4218 version 11262007 will be sent with the application to obtain medical authorization from the applicant. This HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

Medicare Duplication Notice form MI9F-4185RC is being filed for your approval. This form is required for limited policies marketed to the Medicare eligible individuals. A copy will be left with the applicant. I would like to request approval of this form so it can be used with any similar products the company may have approved in the future.

The Toll-Free Customer Service Notice, MIR-AR-763 will be delivered with the policy, as required by law. Form UR-AR-763 was previously approved by your Department on April 21, 2008 under Serff Filing MDIC-125606274. This new form is identical to the previous form except the Customer Service Department and Policyholder Service Department has been combined and is now called Client Services Department. I would like to request approval of this form so it can be used with any similar products the company may have approved in the future.

Replacement Notice MI9F-1060 will be used when required by state law. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 and is enclosed here for informational purposes, only.

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy . This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274 is enclosed here for informational purposes, only.

We will not attach any elimination waivers or riders to exclude, limit or reduce coverage or benefits for named pre-existing conditions or physical conditions beyond any stated waiting period.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Luanne Melies
Compliance Analyst
1-800-695-5976 Ext. 249
Fax (402) 391-4858
lmelies@gomedico.com

ARKANSAS
INSURANCE DEPARTMENT

Lee Douglass
Insurance Commissioner

400 University Tower Bldg.
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2900

ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT

COMPANY NAME Medico Insurance Company

COMPANY NAIC CODE: 31119

COMPANY CONTACT PERSON & NUMER: Luanne Melies 1-800-695-5976 ext. 249

INSURANCE DEPARTMENT USE ONLY

ANALYST:_____ **AMOUNT:**_____ **ROUTE SLIP:**_____

ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS, UNLESS OTHERWISE INDICATED.

FEE SCHEDULE FOR ADMITTED INSURERS

RATE/FORM FILINGS

Life and/or Disability policy form filing and review, per each policy, contract, annuity form, per each insurer, per each filing.
* 1 x $50 = $50.00
** Retaliatory _____

Life and/or Disability - Filing and review of each rate filing or loss ratio guarantee filing, per each insurer.
*_____ x $50 = _____
** Retaliatory _____

Life and/or Disability Policy, Contract, or Annuity Forms: Filing and review of each certificate, rider, endorsement or application if each is filed separately from the basic form.
*_____ x $20 = _____
** Retaliatory _____

Policy and contract forms, all lines, filing corrections in previously filed policy and contract forms.
*_____ x $20 = _____
** Retaliatory _____

Life and/or Disability: Filing and review of Insurer's advertisements, per advertisement, per each insurer.
*_____ x $25 = _____
** Retaliatory _____

AMEND CERTIFICATE OF AUTHORITY

Review and processing of information to amend an Insurer's Certificate of Authority.
*_____ x $400 =_____

Filing to amend Certificate of Authority.
***____ x $100 =_____

*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND REGULATION 57.

** THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE ANN. 23-63-102, RETALIATORY TAX.

*** THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN §23-61-401.